CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				l` ´	X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	01	COMPL		
		155596	B. WIN			06/17/2	011	
NAME OF D	PROVIDER OR SUPPLIER		-	STREET	ADDRESS, CITY, STATE, ZIP CODE	•		
INAME OF P	KO VIDEK OK SUPPLIEK			500 N \	WILLIAMS ST			
LAKELAND SKILLED NURSING AND REHABILITATION				ANGOL	_A, IN46703			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	AN OF CORRECTION		
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	•	TAG	DEFICIENCY)		DATE	
K0000								
	A Life Safety Co	odo Pocortification	K	0000	This Plan of Correction is the			
	A Life Safety Code Recertification and State Licensure Survey was		120	,000	center's credible allegation of			
					compliance.Preparation and /or			
		he Indiana State			execution of this plan of			
	Department of				correction does not constitut admission or agreement by t			
	accordance witl	h 42 CFR 483.70(a).			provider of the truth of the fa			
	_				l ·	al-leged or conclusions set forth		
	Survey Date: 0	6/17/10			in thestatement of deficience			
					The plan of correction is pre and/or executed solely beca			
	Facility Number				is required by theprovisions			
	Provider Numbe	er: 155596			federal and state law.			
	AIM Number: 1	00290510						
	Surveyor: Amy Kelley, Life Safety Code Specialist							
	At this Life Safety Code survey,							
	Lakeland Skilled	d Nursing and						
	Rehabilitation v	vas found not in						
	compliance wit	h Requirements for						
	Participation in							
	Medicare/Medi	caid, 42 CFR						
	Subpart 483.70							
		he 2000 edition of						
	the National Fir							
		PA) 101, Life Safety						
		apter 19, Existing						
		cupancies and 410						
	IAC 16.2.							
		Constitution of the consti						
	This one story	·						
	determined to l	be of Type V (111)						
LABORATOR'	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE	

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D8YJ21

Facility ID:

000474

If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/17/2011		
NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE  500 N WILLIAMS ST  ANGOLA, IN46703				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	alarm system we detection in the open to the corresident rooms. The facility has and had a cens of this survey.  Quality Review by I Safety Code Special 06/21/11.  The facility was compliance with aforementioned.	ne facility has a fire with smoke e corridors, areas ridors and all on the 300 hall. a capacity of 75 us of 69 at the time  Robert Booher, REHS, Life ist-Medical Surveyor on found not in hithe					
K0130 SS=E	Based on observeriew and interfailed to ensure maintenance of doors was in action NFPA 80. NFPA the Standard for Fire Windows, Strequires all hor	rview; the facility the care and f 1 of 1 rolling fire	K0130	It is the policy of this facility toensure the care and maintenanceof all horizonal a vertical sliding and rolling firedoors and to maintain writercords of the maintenance a inspection of the doors. The refire door located be-tween the kitchen and the dining room inspected on 6-29-11 and is in proper working order. (see Attahment A) The rolling fire twas added to the monthly fire	tten nd olling ne was n		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	ĺ	LDING	NSTRUCTION  01	(X3) DATE COMPI 06/17/2	LETED
NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN46703				
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	check for proper full closure. Reference mechanin accordance with manufacturer's written record and shall be made authority having deficient praction resident, staff of main dining room.  Findings include Based on obsert Maintenance Support of the main dining fire door was in did close upon fire alarm. Bas with the Maintenance at 1:30 p.m., the documentation	nism shall be done with the instructions. A shall be maintained ade available to the g jurisdiction. This ce could affect any or visitor in the om.  e:  vation with the upervisor on 2:30 p.m., there re door protecting om the kitchen to g room. The rolling in a corridor wall and activation of the ed on interview enance Supervisor incre was no of an annual est, to check for			form to be monitored during active fire drill for proper functioning. Anymalfunction reported to the Main-tenand department and will be regimmediately. (See Attachmed B) All Department Manager Dietary Staff were inserviced on 6-30-11 about the proper release and resetting of the release mech-anism of the door. (See Attachment C) C of the fire drill reports will be submitted to the Safety Committee each mon for review. The Safety Committee for review a meetings. The QA committer responsible to the Administ responsible to the Administration responsible to the Administration responsible to the Administration respo	rolling opies e the ttheir ee is	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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